STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/23/24 through 6/26/24. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		7/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/18/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 655	Continued From page 1 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a baseline care plan which addressed the immediate needs of the residents for 1 of 5 (#117) newly admitted residents reviewed. The findings were: 1. Review of the medical record for resident #117 showed the resident was admitted from the hospital on 6/6/24 and had diagnoses which included hypertensive chronic kidney disease with stage 5 chronic kidney disease and dependence on renal dialysis. Review of the resident's 6/7/24 baseline care plan showed the focus area of dialysis was left blank.	F 655	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH	

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F 655	Continued From page 2 2. Interview on 6/26/24 at 10:40 AM with the DON confirmed the resident's baseline care plan was incomplete.	F 655	FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Baseline care plan for Resident #117 in regard to dialysis was corrected and updated to reflect resident□s diagnosis on 6/24/24 by Director of Nurses (DON) DON was educated by Director of Clinical Operations (DCO)on 6/24/24 regarding dialysis residents, base line care plans which address the immediate needs of residents, need for communications binder and accurate assessments are done. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Audit done for dialysis resident□s on 6/26/24 by Social Services Director (SSD) to ensure comprehensive care-plans reflect resident□s diagnosis, and immediate needs, corrections were done at that time. III. MEASURES OR SYSTEMIC	

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F 655	Continued From page 3	F 655	CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education provided to nursing staff 6-26-24 by Director of Nurses (DON)on comprehensive care plans, baseline care plans, timeliness of them and focus area Education provided to Social Services Director on 6/26/24 by DON on base line and comprehensive care-plan timeline and focus areas IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Don/Designee will audit admissions daily for compliance with baseline care-plans and weekly charting, care-plans and documentation related to dialysis residents and will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings review and recommendations for 3 months. QAPI committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible for following up on any recommendations by the QAPI Committee.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		7/22/24

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F 657	Continued From page 4 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interview, and policy and procedure review, the facility failed to ensure the comprehensive care plan was revised as needed to reflect the resident's current needs for 1 of 5 sample residents (#58) reviewed for smoking. The findings were: 1. Review of the 3/10/24 MDS assessment showed resident #58 had a BIMS score of 5 out	F 657	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE	

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F 657	Continued From page 5 of 15 which indicated severe cognitive impairment. Interview with the resident on 6/25/24 at 8:19 AM revealed s/he smoked on a regular basis. Review of the 6/17/24 safe smoking assessment showed the resident was required to wear a smoking apron. The following concerns were identified: a. Review of the resident's care plan showed the care plan had not been revised to include goals and interventions related to the use of tobacco. 2. Interview with the DON on 6/25/24 at 2:15 PM confirmed the care plan had not been updated to reflect the resident's use of tobacco. 3. Review of the 5/2/24 Resident Smoking Policy showed "...8. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan...10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan."	F 657	IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: resident #58 care plan was updated 6/26/24 by Director of Rehabilitation (DOR) and includes goals and interventions related to the use of tobacco. Director of Nurses was educated by Director of Clinical Operations on 6/26/24 on Care plans, goals and interventions related to the use of tobacco and safety smoking policy II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: 100% of resident□s charts were audited 6/26/24 by DOR. Care plans audited on 6/26/24 for any identified residents who	

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F 657	Continued From page 6	F 657	smoke to ensure goals and interventions were present. No other issues were identified. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Care plan education conducted by DON on 6/26/2024 in regard to comprehensive care plans, goals BIMs score interventions and smoking policy safety measures. A written nursing communication binder was created 6/27/24 at each nurse□s station by Director of Nurses containing education on comprehensive care plan requirements. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Don/Designee will review new admissions daily and report as needed to Social Worker of any new smokers, daily rounding of smoking area will be done by Executive Director/Designee to ensure safe smoking, Care plans, charting and documentation of assessments related to smoking will be audited weekly by DON/Designee. Don/Designee and Executive Director Designee will reported to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings review	

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F 657	Continued From page 7	F 657	and recommendations for 3 months. QAPI committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible for following up on any recommendations by the QAPI Committee.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure the environment was free of accident hazards for 1 of 5 sample residents (#117) reviewed for smoking. The findings were: 1. Review of the 6/9/24 admission MDS assessment showed resident #117 had a BIMS score of 15, which indicated the resident was cognitively intact, and was coded as not using tobacco. The findings were: a. Observation on 6/23/24 at 11:36 AM showed the resident was smoking in the designated outdoor smoking area under staff supervision.	F 689	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF	7/22/24

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F 689	Continued From page 8 b. Interview with the resident on 6/25/24 at 7:56 AM revealed the s/he did not start smoking until 2 weeks after s/he was admitted. The resident stated s/he wore a smoking apron while smoking but otherwise did not have any restrictions. c. Review of the smoking assessment dated 6/6/24 showed the resident was a non-smoker. There was no evidence a safe smoking assessment had been completed after the resident had chosen to begin smoking. 2. Interview with the DON on 6/25/24 at 2:22 PM revealed a safe smoking assessment had not been completed. 3. Review of the policy and procedure provided by the DON on 6/25/24 at 1:50 PM showed "...5. All resident's will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. 6. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan..."	F 689	PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: resident #117 had Safe smoking assessments completed on 6/26/24 and care plans updated, by Director of Rehabilitation (DOR) Director of Nurses was educated by Director of Clinical Operations on 6/26/24 on admission process for smokers, Care plans, goals and interventions, and safe smoking assessment as well as safety smoking policy II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Charts for residents identified as smokers audited 6/26/24 by DOR for safe smoking assessments and care plans No other issues were identified. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT	

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F 689	Continued From page 9	F 689	OCCUR AGAIN: Education conducted by DON on 6/26/2024. to nurses, social services, MDS on admission assessments, safe smoking, rounds to smoking area, Policy on who needs/does not need supervision and what equipment should be present, and care plans. Education conducted by DON on 6/26/2024 to Nursing Assistants on safe smoking rounds to smoking area, policy on who needs/ does not need supervision and what equipment should be present and how to look for information on care plans IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Don/Designee will review new admissions daily and report as needed to Social Worker of any new smokers, daily rounding of smoking area will be done by Executive Director/Designee to ensure safe smoking, Care plans, charting and documentation of assessments related to smoking will be audited weekly by DON/Designee. Don/Designee and Executive Director Designee will report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings review and recommendations for 3 months. QAPI committee will evaluate and determine the effectiveness of the plan to ensure	

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F 689	Continued From page 10	F 689	substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible for following up on any recommendations by the QAPI Committee.	
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to have a system in place to ensure communication with the dialysis center was documented in the medical record for 3 of 4 residents (#11, #35, #117) who received dialysis services. The findings were: 1. Review of the medical record showed resident #11 was admitted to the facility on 5/13/24, discharged with return anticipated on 5/20/24, and readmitted to the facility on 5/26/24. Review of the resident's care plan showed the resident was to receive dialysis from an offsite dialysis center every Monday, Wednesday, and Friday. Review of the 2024 May and June Dialysis Communication Record forms between the dialysis center and the facility showed no documentation for the 5/17, 5/31, 6/12, 6/17, 6/19, 6/21, and 6/24 treatments. 2. Review of the 3/31/24 quarterly MDS	F 698	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND	7/22/24

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F 698	Continued From page 11 assessment showed resident #35 was admitted to the facility on 9/24/23 and received dialysis services. Review of the physician orders showed the resident was to receive dialysis from an offsite dialysis center every Tuesday, Thursday, and Saturday. Review of the 2024 March, April, May, and June Dialysis Communication Record forms between the dialysis center and the facility showed no documentation for the 3/5, 3/7, 3/9, 3/21, 6/4, 6/6, and 6/8 treatments. 2. Review of the medical record for resident #117 showed s/he was admitted to the facility on 6/6/24. Review of the physician orders showed the resident was to receive dialysis from an offsite dialysis center every Monday, Wednesday, and Friday. Review of the June 2024 Dialysis Communication Record forms between the dialysis center and the facility showed no documentation for the 6/12 treatment. 3. Interview on 6/25/24 at 3:26 PM with RN #1 revealed the facility used to have dialysis binders to keep track of the communication forms; however, the facility had discontinued the binders.	F 698	SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Dialysis Communication/appointment Books were created for Residents #11, #35 and #117 who receive dialysis services by Director of Nurses on 6/26/24 RN#1 Was educated by Director of Nurses on 6/25/24 on the importance of the dialysis communication book, and ensuring the form is being utilized with documentation in medical records, as well as follow up and treatment between dialysis and community are being received and followed up with physician if/when needed. Director of Nurses was educated by Director of Clinical Operations on 6/24/24 on the importance of the dialysis communication book, and ensuring the form is being utilized with documentation, as well as follow up and treatment between dialysis and community are being received and followed up with physician if/when needed. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Dialysis resident charts audited 6/26/24 by	

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F 698	Continued From page 12	F 698	DON. Nursing documentation and scanned dialysis documents audited on 6/26/24 on all dialysis residents, items found deficient were corrected at that time. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education given to nurses for dialysis binder communication & assessment documentation requirements in medical records was conducted by DON on 6/26/2024. A written nursing communication binder was created 6/27/24 at each nurse□s station by Director of Nurses (DON) containing education on dialysis charting and binder documentation requirements. Monthly mandatory nursing meetings will be held to educate nurses on dialysis binder instructions, And charting in medical records. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Don/Designee will audit dialysis binder daily, charting and documentation of assessments related to dialysis weekly and will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings reviews and	

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F 698	Continued From page 13	F 698	recommendations for 3 months. QAPI committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible for following up on any recommendations by the QAPI Committee.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		7/22/24

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F 732	Continued From page 14 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure the daily staff posting was updated daily for 1 of 2 random observations (6/23/24). The census was 64. The findings were: 1. Observation on 6/23/24 at 1:34 PM showed the facility's daily staff posting was on the front wall by the main entrance and was dated 6/20/24. 2. Observation on 6/23/24 at 5:30 PM showed the staff posting had been changed to Sunday 6/23/24. Interview with the nursing home administrator at that time confirmed the posting had been recently changed to reflect the current day's information. 3. Interview with the scheduler on 6/24/24 at 10:39 AM revealed she was normally responsible for the daily staff posting; however, she did not work weekends. In addition, the scheduler confirmed she did not change the daily staff posting on Friday 6/21/24, because she was working on the floor. The scheduler was not aware of whose responsibility it was on the weekends to update the posting. 4. Interview with the DON on 6/24/24 at 10:39 AM	F 732	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT	

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F 732	Continued From page 15 revealed it was the responsibility of the manager on duty to update the daily staff posting on the weekend.	F 732	PRACTICE: The daily staff posting was updated on 6/23/24 to reflect correct date, and daily staff working by Staffing coordinator Education given to Nursing Home Administrator (NHA) on 6/24/04 by Director of Nursing Home Operations on regulation regarding staff postings and rounding daily for compliance. Education given to Senior Management team who consist and rotate as Manager on Duty(MOD) on weekends by NHA on MOD responsibilities including rounding to ensure staff postings are posted daily including weekends and have correct date and staff on 6/24/2024 Education given to scheduler by Director of Nurses (DON) on whose responsibility it is on weekends, or if she is working the floor to update the daily postings with the correct information . II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Audit completed on 6-24/24 by Director of Nurses in all areas that staff postings are visible to ensure they were updated and clearly reflect accurate data. III. MEASURES OR SYSTEMIC	

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F 732	Continued From page 16	F 732	CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education given to Senior Management team on 6-24-2024 by Executive director on correct way to do daily staffing postings to ensure data is correct including weekends Education given to clinical line staff on 6-24-2024 by Director of Nurses on updated staffing postings, where they are posted. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The DON/ designee will audit the daily staff posting 2 times a week for one month, then weekly for one month, then monthly for one month. The Don/designee will be responsible for reporting monthly to the Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for 3 months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure Substantial compliance is achieved and determine if further monitoring and evaluation is required. The Dietary Manager/Designee will be responsible for following up on any recommendations made by the QAPI Committee.	
F 883 SS=D	Influenza and Pneumococcal Immunizations	F 883		7/22/24

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F 883	Continued From page 17 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 883		

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F 883	Continued From page 18 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility policies, and review of the CDC immunization recommendations, the facility failed to ensure residents received the pneumococcal immunization based on CDC recommendations for 1 of 5 sample residents (#43) reviewed for immunizations. The findings were: 1. Review of the medical record showed resident #43 was 79 years old. Further review showed the resident received the Prevnar 23 vaccine on 1/18/17 and had signed a consent form on 9/11/23 to receive the PCV20 vaccine. There was no evidence the resident had received the vaccination. 2. Interview with the infection preventionist on 6/26/24 at 11:09 AM revealed the resident had not been administered the PCV 15 or PCV20 vaccine due to an oversight.	F 883	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND	

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F 883	Continued From page 19 3. Review of the 9/8/23 Pneumococcal Vaccine policy showed "...The type of pneumococcal vaccine (PCV15, PCV20, or PPSV23) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations." 4. According to the Adult Immunization Schedule by the CDC located at https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-schedule-notes.html#note-pneumo (accessed on 6/27/24) showed individuals 65 or older who previously received only the PPSV23 vaccine should be administered either the PCV15 or PCV20 at least 1 year after the PPSV23 dose.	F 883	SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 43 was given (PCV20) on 6/28/24 by infection Control nurse. (ICP) Infection Control Nurse was Educated on 6/27/24 by Director of Nurses (DON) on CDC recommendations and facility Policy on Immunizations II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Resident charts audited 6/28/24 by ICP. Immunizations documentation audited on 6/26/24 on all residents by ICP nurse no other deficient practices were found III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education given to nurses in regards to CDC recommendations and review of facility Policy on 6/28/24 by Director of Nurses Weekly audits started on 6/28/24 by ICP and follow up with DON and NHA to ensure all new required vaccines are	

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F 883	Continued From page 20	F 883	administered. consent/declination forms signed within 2 weeks of admission and added to PCC vaccine charting, this will be audited by ICP weekly and started 6/28/24 IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: ICP/Designee will audit vaccine template, epic medical records the ICP/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings review and recommendations for 3 months. QAPI committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible for following up on any recommendations by the QAPI Committee.	